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THE EFFECTS OF SOCIAL SUPPORT AND PERSONAL HISTORY OF TRAUMATIC EVENTS ON CHILD WELFARE WORKERS

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The Effects of Social Support and Personal History of Traumatic Events on Child Welfare Workers

Introduction

Every day children are physically abused, sexually assaulted, and neglected by their parent or caretaker. Approximately 875,000 children are severely harmed by family members in the United States annually (U.S. Department of Health and Human Services, 2004). Child maltreatment is a serious problem that affects many families in the state of Oregon. Child welfare workers received approximately 55,000 reports of suspected child abuse and neglect in 2005, an increase of 18.5% since 2004 (Oregon Department of Human Services, 2006). Further, there were 11,255 unduplicated child abuse and neglect victims in 2005, a 6% increase since 2004. Because of the severity and the growing number of child maltreatment cases, child welfare workers must increasingly intervene directly with children on a daily basis to assess whether abuse or neglect has occurred.

Child welfare workers who work with maltreated children and their families are exposed to traumatic material on a daily basis. Hearing about traumatic experiences can lead to vicarious traumatization (Pearlman & Mac Ian, 1995), secondary traumatic stress (Figley, 1995a), and burnout (Maslach, 1982). Vicarious traumatization (VT) refers to the cumulative impact on mental health professionals of working with clients who have experienced traumatic events and can result in a disruption in cognitive schemas (Pearlman & Mac Ian, 1995). Secondary traumatic stress (STS) occurs when mental health professionals begin to suffer symptoms similar to posttraumatic stress disorder following frequent exposure to their clients' traumatic events (Figley, 1995a). Burnout occurs when professionals begin to

dehumanize their clients, become emotionally exhausted, and lose a sense of personal accomplishment at work (Maslach, 1982).

Considerable research has been conducted on effects of working with child abuse survivors on therapists (Follette, Polusny, & Milbeck, 1994); however, less research has been conducted on the effects of such work on child welfare workers (Cornille & Meyers, 1999). Caseworkers, similar to therapists, are vulnerable to developing vicarious traumatization, secondary traumatic stress, and burnout (Nelson-Gardell & Harris, 2003; Savicki & Cooley, 1994). However, child welfare workers may have larger caseloads than therapists and therefore are likely to be exposed to a broader range of traumatic information than therapists. It is important to further investigate the effects on child welfare workers of working with child abuse survivors in order to identify factors that may play a role in the development of vicarious traumatization, secondary traumatic stress, and burnout. Identifying these factors will be beneficial because it may help to ameliorate, prevent, or reduce the effects of vicarious traumatization, secondary traumatic stress, and burnout in child welfare workers. Personal history of traumatic experiences and level of perceived social support from friends, family, significant others, colleagues, and supervisors are associated with the development of VT, STS and burnout among mental health professionals (Follette, Pilusny, & Milbeck, 1994; Jayaratne, Chress, & Kunkel, 1986; Kassam-Adams, 1999; Lerias & Bryne, 2003; McLean, Wade, & Encel, 2003; Motta, Suozzi, & Joseph, 1994; Pearlman & Mac Ian, 1995; Trippany, 2001; Weiss et al., 1995). In turn, level of perceived social support from friends, family, significant others, colleagues, and supervisors are associated with the intention to leave one's job (Ellet, 2000; Ellet & Millar, 2004; Mor Barak, Nissly, & Levin, 2001; Nissly, 2004; Rycraft, 1994; Smith, 2005). Specifically, higher levels of perceived support were

positively associated with job retention (Smith, 2005). In this study, the relationship between perceived social support and a personal history of traumatic events with VT, STS, and burnout among child welfare workers will be examined. Furthermore, the relationship between level of perceived social support and intention to remain employed will be investigated.

Vicarious Traumatization

Clinicians working with traumatized clients are at risk for developing adverse reactions as a result of their "exposure to emotionally shocking images of horror and suffering that are characteristic of serious trauma" (McCann & Pearlman, 1990a, p.134). They are asked to hold and absorb their client's traumatic material while also maintaining the ability to offer hope, support, and empathy to their client. This can put a considerable amount of strain on a clinician's emotional health and psychological well-being.

Undoubtedly, many mental health workers find that working with survivors of traumatic events is meaningful and rewarding, and believe that they are privileged to witness their client's strength and resilience in the healing process (Kassam-Adams, 1995). However, the challenges of frequent exposure to traumatic events may be difficult to overcome. Traumatic events involve actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 2000). Examples of traumatic events that clients may endure include physical or sexual assault, childhood sexual abuse, domestic violence, school or work-related violence, natural disasters, and combat-related events.

The term vicarious traumatization (VT) was proposed to provide a theoretical framework for describing the complicated and often painful effects of working with clients

with histories of traumatic events on mental health professionals (McCann and Pearlman, 1990a). VT can be defined as "a transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995a, p. 151). This material may include "graphic descriptions of violent events, realities of people's cruelty to one another, and trauma-related re-enactments" (Pearlman & Saakvitne, 1995b, p. 31). VT results from the cumulative impact of working with clients who have experienced traumatic events.

Working with victims of traumatic events can cause profound psychological effects in clinicians that can interfere with their personal and professional lives (Pearlman & Saakvitne, 1995a).VT effects clinicians' sense of self, others, and their perceptions of the world. It emphasizes the way the clinician's experience of the self is altered in terms of affect tolerance, identity, world view, sense of meaning, spirituality, self capacities, ego resources, psychological needs, and the sensory motor system (i.e., imagery). VT provides a framework that can help us understand how repeated exposure to traumatic events can effect clinicians' beliefs and feelings, in the areas of safety, trust, esteem, intimacy, and control (Pearlman & Saakvitne, 1995b). It can cause difficulty in interpersonal relationships and lead them to perceive the world as unsafe and people as untrustworthy.

After being exposed to clients' traumatic material, clinicians often experience immediate strong reactions including feelings of grief and anger as they hear about the torture, humiliation, and betrayal that human beings are capable of committing (Canfield, 2005). As a result, clinicians may feel a deep sense of loss, numbing, and sorrow. Mental health professionals who are unable to resolve their symptoms of VT may become cynical,

withdrawn, and may have difficulty understanding their clients' hopelessness and despair (Pearlman & Saakvitne, 1995b).

Constructivist Self Development Theory

The theory of trauma and adaptation called constructivist self-develop theory (CDST) provides a comprehensive conceptual framework for understanding how VT develops. CDST theorists claim that mental health professionals who are working with clients with traumatic events experience a disrupted sense of self, including changes to their cognitive schemas and imagery systems of memory (McCann & Pearlman, 1992). The basis of this theory is that individuals construct their own reality through the development of cognitive schemas, which in turn facilitate how individuals understand different life experiences (Trippany, White Kress, & Wilcoxon, 2004). Cognitive schemas are cognitive structures used by individuals to organize experiences and information to function effectively in a complex, changing environment (Epstein, 1991). Changes occur in individual's cognitive schemas as a result of personal characteristics and interactions with clients' traumatic events. These changes occur through the processes of assimilation, accommodation, and overaccommodation. Assimilation refers to the process by which individuals hold on to previously held beliefs despite contradictory information (i.e., the abuse did not happen; Piaget, 1950). Accommodation occurs when individuals modify their previously held beliefs to accommodate conflicting information (e.g., the world can be an unsafe place, some parents abuse their children; Piaget, 1950). Overaccommodation is a process by which beliefs are modified in an extreme manner, such that these beliefs no longer reflect the experience of the individual (e.g., the world is always unsafe, all parents abuse their children; Resick & Schnicke, 1996).

According to CDST theorists, the various aspects of personality that are affected by traumatic events and are most vulnerable to VT include: self-capacities, ego resources, frame of reference, and psychological needs or other-related cognitive schemas (Pearlman & Saakvitne, 1995b). First, self-capacities are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive esteem" (Pearlman & Saakvitne, 1995b, p. 64). Individuals are able to maintain relationships with others, manage emotions, and sustain positive feelings about the self by utilizing their self-capacities. A disruption to self -capacities occur when an individual loses his or her identity, has difficulty in his or her interpersonal relationships, and has difficulty controlling negative emotions. Second, ego resources allow individuals to meet his or her psychological needs and interpersonally relate to others (Pearlman & Saakvitne, 1995b). Symptoms of disruption to ego resources include the inability to be empathic, perfectionism, and overextension at work. Next, frame of reference can be described as an individual's perspective for understanding the self and the world. While many mental health professionals are exposed to human suffering and violence, it may be extremely difficult for them to comprehend or make sense of the world. It is important for clinicians to develop a meaningful frame of reference or the ability to make sense of their experience. This assists in making the world appear comprehensible, meaningful, and orderly (McCann & Pearlman, 1990b). Last, psychological needs and cognitive schemas include safety, trust, esteem, intimacy, and control needs.

Understanding the five basic psychological needs can clarify VT and how to prevent it in mental health professionals (Trippany et al., 2004). Safety is the need to feel protected and reasonably invulnerable to harm (McCann & Pearlman, 1992). Disruptions in these schemas often reflect a painful loss of mental health workers' preconceived notion of

invulnerability. Mental health professionals often have a heightened concern regarding numerous dangers in the world. Disruptions in this domain are often associated with hypervigilance about possible danger in the world, apprehension, and a heightened sense of vulnerability. Trust or dependency is the need to believe in the promise of another person and to depend upon others to meet one's needs. Mental health workers who are exposed to other people's traumatic events become aware of the many cruel and inhumane ways that people can betray or violate the trust of others. As a result, mental health workers may become less trusting and more suspicious of other's motives. Mental health workers may also experience an increase in their concern about the safety of others. Esteem is the need to be valued by others, to have one's worth validated, and to value others. In general, as mental health workers are increasingly exposed to his or her client's traumatic material, he or she may experience a diminished esteem for other human beings. He or she may lose their belief that people are benevolent and instead believe that all human beings are malicious and cruel. Intimacy is the need to feel connected to others through relationships as well as belonging to a larger community. Those who work with survivors of traumatic events often experience feelings of alienation and estrangement from colleagues who do not work with victims who have experienced a traumatic event. They may also feel increasingly distant from their families, friends, and significant others. Control or power is the need to direct or be in charge of others. Traumatic event survivors often express a sense of powerlessness and hopelessness in response to the traumatic event that they experienced. Those who work with survivors of traumatic events often identifies with the feelings expressed by their clients and may also experience a sense of rage towards the perpetrator. Mental health workers may experience a sense of having little control over tragic or painful life events. Those who work with

survivors of traumatic events have a high need for power, they often attempt to restore this disrupted schema by prematurely encouraging clients to confront or persecute the perpetrator.

Symptoms of Vicarious Traumatization

Symptoms of VT involve cognitive shifts in the areas of safety, trust, esteem, intimacy, and control. Long-term exposure to clients' traumatic events can result in disturbances in mental health workers' basic schemas about the world, such as the belief that the world is safe and people can be trusted (Schauben & Frazier, 1995). These cognitive shifts can interfere with a mental health worker's feelings and relationships with colleagues, clients, friends, and family (Baird & Jenkins, 2003).

Secondary symptoms that may be present in those who work with survivors of traumatic events include intrusive imagery, feelings of personal vulnerability, bystander guilt, and difficulty identifying with the client's helplessness and rage (Neumann & Gamble, 1995). It can lead to nonempathic distancing from clients, boundary violations with clients, questioning one's choice of profession, victim blaming, cynicism, a sense of despair, and a loss of energy and idealism of the client. Symptoms of VT can differ in terms of severity, intensity, duration, and impairment; however if they are left untreated, the results can be pervasive.

Predictors of Vicarious Traumatization

Although not all mental health professionals who work with clients with traumatic event histories develop VT, many variables have been found to predict its occurrence (Baird & Jenkins, 2003; Canfield, 2003; Lerias & Bryne, 2003). Variables associated with VT include previous history of traumatic experience (Pearlman & Mac Ian, 1995; Trippany et al.,

2001; Follette, Pilusny, & Milbeck, 1994) and lower levels of perceived social support (Lerias & Bryne, 2003).

Personal history of traumatic events

Mental health workers with a personal history of traumatic events report higher levels of VT than mental health workers without a history of traumatic events (Cunningham, 2003; Follette, Polusny, & Milbeck, 1994; McLean, Wade, & Encel, 2003; Pearlman & Mac Ian, 1995; Way et al., 2004). For example, among 188 therapists, those with a personal history of traumatic events showed significantly more negative affect (i.e., higher levels of general distress) and symptoms of vicarious trauma (i.e., more disruptions in cognitive schema) than therapists without a history of traumatic events (Pearlman & Mac Ian, 1995). Clinicians own victimization experiences may be re-activated by exposure to clients' trauma histories.

Contrary to these studies, other researchers have found no significant relationship between a history of personal traumatic events and higher levels of VT (Benatar, 2000; Bober & Regehr, 2005; Schauben & Frazier, 1995; Way et al., 1994). For example, among 118 female psychologists and 30 female sexual violence counselors, there was no association between a previous history of traumatic events and increased VT symptomatology (Schauben & Frazier, 1995).

When comparing the conflicting results of these studies, it appears that numerous methodological limitations may have contributed to the finding that no relationship exists between a history of traumatic events and higher levels of VT. First, in the latter study, the definition of a traumatic event was narrowly defined. Specifically, the researchers asked participants if they had previously experienced rape or incest. On the other hand, Pearlman and Mac Ian (1995) asked participants, "Do you have a trauma history?" Another

methodological limitation that may have contributed to the insignificant findings by Schauben and Frazier (1995) included that 68 participants (47%) experienced a traumatic event (i.e., rape or incest) whereas 112 participants (60%) reported that they had experienced a traumatic event in the study conducted by Pearlman and Mac Ian (1995). Thus, it is possible that the larger sample size had greater statistical power and more robust findings. Last, it appears the researchers in these contrasting studies had different conceptualizations of VT. Schauben and Frazier (1995) defined VT as "the enduring psychological consequences for therapists of exposure to the traumatic experiences of victim clients" (p. 53). Examples of VT included nightmares, heightened fear, and increased feeling of vulnerability. The measure that was used to assess VT was not specified; rather the researchers indicated that the measure was supported by its significant correlation with PTSD symptoms, negative affect, and disruptions in beliefs. On the other hand, Pearlman and Mac Ian (1995) defined VT specifically as changes in cognitive schemas. The TSI Belief Scale, a well-validated measure was used to assess levels of VT. PTSD symptomatology was not included in their definition of VT. Based on these studies, it appears likely that exposure to greater amounts of traumatic material is associated with greater levels of VT among child welfare workers.

Perceived level of social support

People with lower levels of perceived social support report higher levels of VT than those with higher levels of perceived social support. Mental health workers who have been exposed to another's traumatic events report higher levels of psychological distress in the context of low levels of social support than mental health workers who report lower levels of

psychological distress (Adams et al., 2001, Follette et al., 1994; Ozer, Best, Lipsey, & Weiss, 2003).

Social support within organizations is important because it has been found to lessen the effects of VT (Catherall, 1995; Follette et al., 1994; Munroe et al., 1995; Oliveri & Waterman, 1993; Rosenbloom, Pratt, & Pearlman, 1995). Similarly, 85% of trauma counselors report consulting with colleagues as their most common method of dealing with VT (Pearlman & Mac Ian, 1995). In a qualitative study of 18 counselors, peer support in the form of debriefing, was the most important strategy for coping with the effects of difficult therapy sessions with domestic violence survivors and helped clinicians manage perceptions of responsibility of complex cases, such as when a counselor had to break confidentiality (Iliffe & Steed, 2000). Peer supervision or consultation with colleagues can offer validation and support, provide clinicians with opportunities to share new information related to therapeutic work, and allow them to vent feelings (Iliffe & Steed, 2000; Oliveri & Waterman, 1993). Colleagues can help peers challenge cognitive distortions of cynicism and mistrust of others. Further, colleagues remind clinicians that they are not alone and can help reduce perceptions of isolation that comes from working with traumatized clients (Pearlman, 1995). Mental health workers who work with survivors of traumatic events should be provided with adequate supervision in order to reduce or ameliorate trauma-related symptoms (Arvay & Uhlemann, 1996; Follette et al., 1994; McCann & Pearlman, 1990a; Sexton, 1999; Sommer, 2003). Supervision can mitigate the effects of VT by assisting clinicians in identifying painful countertransference and transference dynamics that occurred between the clinician and client within the context of the therapeutic relationship. This can be especially important when a clinician has experienced a similar traumatic event to their client (Rosenbloom, Pratt,

& Pearlman, 1995). Inexperienced clinicians are particularly vulnerable to VT when supervision is not provided (Neumann & Gamble, 1995). However, only 64% of therapists who work with clients with histories of traumatic events reported receiving supervision (Pearlman & Mac Ian, 1995). Based on these results, it is possible that mental health workers who receive supervision will have lower levels of VT than mental health workers who do not receive supervision.

Secondary Traumatic Stress

Secondary traumatic stress (STS) differs from VT in its focus and context (Pearlman & Saakvitne, 1995a). STS is based exclusively on the diagnostic conceptualization of post-traumatic stress disorder as defined by the Diagnostic and Statistical Manual for the American Psychiatric Association (APA, 2004) whereas VT is based on the profound changes that occur in a therapist's sense of meaning, identity, world-view, and beliefs about the self and others (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a).

STS is a naturally occurring process that results from learning or hearing about another person's traumatic event and, in the process experiencing traumatic stress (Figley, 1995a). STS, which is synonymous with compassion fatigue (Figley, 1995a), is a syndrome of symptoms that are nearly identical to Posttraumatic Stress Disorder (PTSD), except that the individual does not directly experience the traumatic event. Rather, the individual is exposed to information of the traumatizing event. STS symptoms can emerge suddenly and with little warning, and often appears disconnected from the real cause. Individuals often experience a sense of helplessness, confusion, and isolation from support systems.

Individuals who work directly with or have direct exposure to trauma victims are just as likely as the primary victims to experience traumatic stress symptoms (Figley, 1995a).

"People can be traumatized without actually being physically harmed or threatened with harm. They can be traumatized simply by learning about the traumatic event" (Figley, 1995a, p. 4). However, STS is a natural, predictable, treatable, and preventable unwanted by-product of caring for traumatized people rather than a problem within the therapeutic relationship (Figley, 1995b; Stamm, 1999).

There appears to be four reasons why mental health workers who work with survivors of traumatic events are particularly vulnerable to STS (Figley, 1995a). First, empathy is a major resource for mental health workers to help individuals who have experienced a traumatic event. Empathy can be defined as "the psychobiological capacity to experience another person's state of being and phenomenological perspective at any given moment in time" (Wilson & Lindy, 1994, p. 27). The process of empathizing with a client is an important resource because it first and foremost helps the mental health worker understand the person's experience of being traumatized. Furthermore, the process of empathy assists the mental health worker in assessing the problem and formulating a treatment plan. It is a key ingredient in forming a therapeutic alliance (Figley, 1995a). However, empathy places clinicians at risk for developing STS because during the process of trying to understand the client's traumatic event, the clinician may become indirectly traumatized by the information that the client is sharing (Figley, 1995a). Second, many mental health workers have experienced one or more traumatic events in their lives (Figley, 1995a). Because the clinician may have experienced a traumatic event that is similar to one experienced by his or her client, the clinician may overgeneralize his or her traumatic event. In other words, a clinician may assume that his or her traumatic event is very similar to the client's traumatic event, when in fact they are very different from one another. A clinician may also assume that what

was effective in helping he or she cope with the traumatic event will also be effective in helping the client cope with his or her traumatic event. Third, it is possible that unresolved traumatic events in a worker's life would be activated by reports of similar traumatic events in clients. Mental health workers who have experienced a traumatic event may have unresolved thoughts and feelings about the event. As a result, these thoughts and feelings may be provoked as a result of a client's traumatic experiences (Figley, 1995a). Fourth, children's traumatic events can be particularly challenging for mental health workers because they are exposed to details and consequences of traumatic events that effect children. Powerful emotions, such as feelings of helplessness, rage, desire for retaliation, and disbelief in humans' capacity for cruelness can be elicited when working with children who have experienced a traumatic event (Brady et al., 1999). Mental health workers are most vulnerable to STS when they are exposed to children's traumatic events (Figley, 1995a).

Symptoms of Secondary Traumatic Stress

STS symptoms often appear suddenly, with no warning and occur as a result of hearing emotionally shocking material from their clients (Nelson-Gardell & Harris, 2003). STS symptoms mirror symptoms of posttraumatic stress disorder (PTSD), including reexperiencing the traumatic event (e.g., nightmares, flashbacks, or intrusive images related to the client's traumatic disclosures), avoidance and numbing (e.g., efforts to avoid thoughts about the traumatizing event or material presented by client, social withdrawal), and persistent physiological arousal (e.g., hypervigilance, anxiety, unexplained anger, irritability) (Chrestman, 1999). The degree of impairment experienced by individuals who have been indirectly traumatized varies in severity; however, it appears that these symptoms are not as severe as those who have directly experienced a traumatic event (Brady et al., 1999).

Other symptoms of STS include distressing emotions, disturbed sleep, a sense of helplessness and confusion, thoughts of insanity, suicidal thoughts, somatic complaints, addictive or compulsive behaviors, and impairment of day-to-day functioning in social and personal roles (Collins & Long, 2003; Cornille & Meyers, 1999). Individuals suffering from STS can cause harm to clients by not being able to be attentive and focused, having difficulties with boundaries, missing appointments, and abandoning his or her clients. They may also distance or alienate themselves from their family and friends (Salston and Figley, 2003).

Predictors of Secondary Traumatic Stress

Several variables have been hypothesized to predict STS. A personal history of traumatic events and the level of perceived social support from friends, family, significant other, colleagues, and supervisors are two variables that will be examined in this study.

Personal history of traumatic events

History of traumatic experiences increases the likelihood that an individual will report higher levels of STS (Cornille & Meyers, 1999; Kassam-Adams, 1999; McLean, Wade, & Encel, 2003). A personal history of childhood traumatic events (in the form of child abuse and neglect) increased a child welfare worker's risk for STS (Nelson-Gardell & Harris, 2003). Specifically, child welfare workers who experienced emotional abuse or neglect were more likely to report symptoms of STS than child welfare workers who did not experience childhood maltreatment.

In contrast to many researchers finding a relationship between a personal history of trauma and STS, other researchers have failed to find this relationship (Bober & Regher,

2006). In a study of mental health professionals, no relationship between a history of personal traumatic events and STS was evidenced.

Many methodological limitations may have contributed to the discrepancies between the results of the studies assessing the relationship between STS and a personal history of traumatic events. In the study that found insignificant results, the researchers did not use a psychometrically sound measure to assess mental health professionals' personal history of traumatic experiences (Bober & Regher, 2006). Further, the Impact of Events scale was used to assess STS; however, this scale measures PTSD symptomatology rather than STS symptomatology. On the other hand, Nelson-Gardell and Harris (2003) used the Childhood Trauma Questionnaire to assess for a history of traumatic events and the Compassion Fatigue Self test for Psychotherapists, which specifically assesses STS symptomatology. Both of these scales are well-validated and reliable measures. Another limitation that may have affected the results of the study conducted by Bober and Regher (2006) included that they used participants from a multitude of professions including social work, nursing, psychology, and medicine whereas Nelson-Gardell and Harris (2003) only used child welfare workers. Therefore, given the more robust methodology, it is likely that exposure to greater amounts of traumatic material is associated with greater levels of STS among case workers.

Perceived level of social support

Mental health workers who use social support as a coping mechanism reported fewer PTSD symptoms than those who did not use social support as a coping mechanism (Schauben & Frazier, 1995). Social support is associated with better adjustment after being exposed to traumatic events and mediates the relationship between stressors and distress (Figley, 1995a; Flannery, 1992; Ericksson VandeKemp, Gorsuch, Hoke, & Foy, 2001;

Weiss, Marmar, Metzler, & Ronfeldt, 1995). Those with less social support tend to have more severe distress symptoms (Motta, Suozzi, & Joseph, 1994; Weiss et al., 1995) than those with higher levels of perceived social support (Kassam-Adams, 1999). Moreover, having a diverse network of supportive relationships (i.e., friends, family, significant others, colleagues, and supervisors) and having an appropriate outlet where he or she can share reactions and receive support is particularly important in ameliorating or preventing the effects of STS (Figley, 1995c; Flannery, 1990).

There are four components of social support, including (a) emotional support (i.e., being able to share and ventilate thoughts and feelings with others who listen sympathetically, (b) information (i.e., others being able to provide their knowledge or specific facts to help resolve conflicts or problems that may arise), (c) social companionship (i.e., the presence of others may reduce one's sense of loneliness, helplessness, and vulnerability), and (d) instrumental support (i.e., assisting in problem solving by offering tangible assistance such as providing resources or making phone calls; Flannery, 1990). An individual's professional peer group can provide support in each of these domains. Formal organizational support, such as group consultation, treatment team, case conference, or clinical seminar is most effective at reducing the effects of STS (Neumann & Gamble, 1995). A formally organized group can be supportive by providing resources (e.g., helping with paperwork, making phone calls, and providing backup during non-work hours). This can also help workers experiencing STS by providing empathy and nonjudgmental opportunities to discuss distressing reactions to clients. Group members can reframe and correct cognitive distortions of responsibility that may develop in response to exposure to clients' traumatic experiences and normalize disturbing reactions (Catherall, 1999). They can offer more

objective or accurate perspectives on impairing stress reactions such as losing one's sense of perspective or displaying unethical and unprofessional behavior.

Effective supervision is also an essential component in prevention and reduction of STS (Cerney, 1995). The number of times a worker received non-evaluative supervision and the number hours of non-evaluative supervision were positively correlated to low levels of STS (Dalton, 2001, as cited in Bell, Kulkarni, & Dalton, 2003).

Burnout

Burnout is the result of general psychological distress associated with working with difficult clients, including clients with histories of traumatic events (Trippany et al., 2004). Burnout is a negative internal state that involves feelings, attitudes, motives, and expectations that effects workers in the human services sector (Maslach, 1982). It occurs when mental health professionals begin to dehumanize their clients, become emotionally exhausted, and lose a sense of personal accomplishment at work. Burnout is often referred to as a process (versus a fixed condition) that begins gradually and becomes progressively worse (Maslach, 1982).

Burnout is more often thought of as an organizational problem rather than an individual problem (Nelson-Gardell & Harris, 2003). Often times, mental health workers find themselves struggling with conflicting organizational policies and structures and organizational goals of promoting the well-being of their clients (Karger, 1981; Barr; 1984). In a recent qualitative study, all of the participants cited the agency and office working conditions as significant stressors (Dane, 2000). Other researchers have identified work overload, large caseload, and long hours as factors that can lead to burnout (Baird & Jenkins, 2003). Burnout can also result from the conflict between excessive responsibilities, a sense of

having no control over the quality of services provided, awareness of little emotional or financial reward, a sense of loss of community within the work setting, and the existence of equity or lack of respect at the workplace (Maslach & Leither, 1996). Clinicians who are overcommitted and over dedicated are the most vulnerable to burnout (Freudenburger, 1997).

On the other hand, positive factors that can ameliorate burnout include work autonomy and high levels of social support (i.e. supervision, communication, praise). Organizations can often make an effort to reduce burnout by rotating staff assignments, decreasing workloads, and encouraging staff to take time off from work.

Symptoms of Burnout

There are six categories of symptoms of burnout (Kahill, 1988b). These include (a) physical symptoms (e.g. fatigue and physical depletion or exhaustion, sleep difficulties, somatic problems such as headaches, colds, flu, and gastrointestinal difficulties), (b) emotional symptoms (e.g. emotional depletion, feelings of helplessness, irritability, guilt, depression, anxiety), (c) behavioral symptoms (e.g. aggression, substance abuse, pessimism, a rigid reliance on rules, absenteeism, overeating, excessive smoking), (d) work-related symptoms (e.g. poor work performance, excessive absences, tardiness, misuse of work breaks, turnover), (e) interpersonal symptoms (e.g. inability to concentrate, inhumane practice with clients, difficulty communicating, withdrawal from friends and family), and (f) attitudinal symptoms (cynicism, callousness, pessimism, defensiveness, intolerance of clients, loss of enjoyment at work, resistance to going to work.

Predictors of Burnout

Personal history of traumatic events

Therapists who identified themselves as working primarily with clients with a history of traumatic events and those who had experienced a traumatic event evidenced a higher score on the Maslach Burnout Inventory (MBI) than those who had not experienced a traumatic event (McLean, Wade, & Encel, 2003). In contrast, in a study of mental health practitioners who worked with maltreated children, a personal history of maltreatment was not associated with high levels of burnout (Stevens & Higgins, 2002). The sample size in this study was 44 participants compared to in the prior study, which included 116 participants. Because the latter study had fewer participants, it may have less power to detect a significant relationship between burnout and a personal history of traumatic events. Further, participants in the latter study were only asked about five types of traumatic events that they may have experienced as a child, which included sexual abuse, physical abuse, psychological maltreatment, neglect, and witnessing family violence. It is possible that that there are other traumatic events that contribute to higher levels of burnout. On the other hand, the study conducted by McLean et al., (2003) asked the question, "Have you yourself been directly involved in a traumatic incident in your personal or work life in the past six months?" Based on the more robust findings, it is likely that personal history of traumatic events is associated with higher levels of burnout.

Perceived level of social support

In general, researchers have found that social support protects against burnout because it mitigates the effects of stressful or traumatic experiences (Capner & Caltabiano, 1993; Coster & Schwebel, 1997; Etzion, 1984, Kahill, 1988a; Koeske, Kirk, & Koeske,

1993; Koeske & Koeske, 1989; Leiter, 1988; Ross, Altmaier, & Russell, 1989; Ross, Altmaier, & Russell, 1989; Savicki & Cooley, 1987). Social support, especially the support of one's colleagues and supervisors, was identified as the coping strategy that reduces the likelihood of burnout in child welfare workers (Parry, 1989). In a study of child welfare workers, the researchers found that those who had high burnout scores were significantly less satisfied with their marriages than those who had low burnout scores (Jayaratne, Chress, & Kunkel, 1986). In a similar study, higher levels of perceived support were associated with lower levels of burnout and stress symptoms (Davis-Sacks, Jayaratne, & Chress, 1985). Specifically, high levels of perceived social support were associated with a high sense of personal accomplishment (a subscale on the MBI). Similarly, in a study of Child Protective Service (CPS) workers, researchers found that social support had a significant effect on the personal accomplishment and depersonalization subscales on the MBI, but not on the emotional exhaustion subscale (Anderson, 2000). In particular, engaged coping strategies and attempts to actively manage stress were associated with a diminished sense of depersonalization and a greater sense of personal accomplishment.

Summary

Although considerable research has been conducted on VT, STS, and burnout among therapists and crisis workers (i.e. paramedics, firefighters, police officers), less research has been conducted on VT, STS and burnout among child welfare workers (Cornille & Meyers, 1999). However, it is evident that child welfare workers are also exposed to children's traumatic experiences on a daily basis through interviewing victims, reading client files, and investigating accusations. Therefore, it is likely that child welfare workers are vulnerable to VT, STS, and burnout. This study was designed to investigate the role of personal history of

traumatic events and perceived level of social support from friends, family, significant others, colleagues, and supervisors in the development of VT, STS, and burnout among child welfare workers. Specific hypotheses are as follows: (a) child welfare workers who report lower levels of perceived social support from friends, family, significant others, supervisors, and colleagues will report higher levels of VT, STS, and burnout than child welfare workers who report higher levels of perceived social support, (b) child welfare workers who report lower levels of perceived social support from friends, family, significant others, supervisors, and colleagues will report an increased intention to leave their jobs than workers who report higher levels of social support, and (c) child welfare workers who report higher levels of VT, STS, and burnout will report a higher number of previous traumatic events than child welfare workers who report lower levels of VT, STS, and burnout.

Methods

Participants

Participants in this study included 127 child welfare workers who work with children who have been maltreated. Child welfare workers were recruited from two counties in the state of Oregon and voluntarily agreed to participate in the study. Child welfare workers length of employment in their organizations ranged from 1 month to 40.25 years with a mean length of 5.72 years. The sample included 96 females (75.6%) and 31 males (24.4%). Participants' ages ranged from 22 to 63 years with a mean age of 37.54. The sample was comprised of 98 Caucasians (77.2%), 12 Hispanics (9.4 %), 7 African Americans (5.5%), 6 Asians (4.7%), and 4 other (3.1%). Eighty-six child welfare workers were married (67.7%), 20 were single (15.7), 14 were divorced (11%), 2 were separated (1.6%), 1 was widowed

(.8%), and 3 were other (2.4%). Eighty-one participants indicated that they were parents (63.8%) while 46 indicated that they were not parents (36.2%).

The sample included 96 Social Service Specialists I (75.6%), 10 Social Service Specialists II (7.9%), 13 Social Service Assistants (10.2%), and 8 Child Welfare supervisors (6.3%). Eighty-four child welfare workers indicated that they worked over 40 hours per week (66.1%), 35 child welfare workers indicated that they worked between 31 and 40 hours per week (27.6%), 6 child welfare workers indicated that they worked between 21 and 30 hours per week (4.7%), and one child welfare worker reported that he or she worked between 10 and 20 hours per week (.8%).

Participants in this study varied greatly on the number of families in their caseload. Twenty-seven child welfare workers reported that they had between 11 and 15 families on their caseload (21.3%) and 20 child welfare workers reported that they had between 16 and 20 families on their caseload (15.7%). Furthermore, 29 child welfare workers reported that they had 21 or more families on their caseload (22.8%) and 18 child welfare workers reported that they had 0 to 10 families on their caseload. Twenty-three child welfare workers (18.1%) reported that this question was not relevant to their current job position.

Design and Procedure

Child welfare workers and their supervisors employed by the Department of Human Services (DHS) volunteered to participate in this study. Child welfare workers with job titles of Social Service Specialist I, Social Service Specialist II, Social Service Assistant, and Child Welfare supervisor were included in this study. These groups were chosen to participate in this study because they have direct or face-to-face contact with clients. Other employees of

DHS were excluded from this study because they did not have direct face-to-face contact with clients.

Child welfare workers were recruited via announcements at staff meetings. Child welfare workers who voluntarily participated in the study were entered into a drawing to win 1 of two $50 gift certificates to Target. The participants were also given a free lunch as an incentive to complete questionnaires. All child welfare workers who agreed to participate in the study signed an informed consent form (see Appendix A). Data collection consisted of a one-time administration of questionnaires. Data were entered into SPSS 14.0, cleaned, and analyzed.

Measures

Vicarious Traumatization. The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) is a self-report measure of beliefs about the self and others that are related to dimensions commonly effected by traumatic experiences. These dimensions include perceptions of safety, trust, esteem, intimacy, and control. For each of these dimensions, 10 scale scores reflecting "beliefs about self" and "beliefs about others" are produced. The TABS consists of 84 items on a six-point Likert scale ranging from 1 (*disagree strongly*) to 6 (*strongly agree*). The TABS has high internal consistency (alpha=.96) and good test-retest reliability (r = .75) (Aidman & Garro, 2005). TABS scores were highly correlated with scores on the Trauma Symptom Inventory (supporting convergent validity). Criterion validity was demonstrated by predictable differences in TABS scores between groups who had experienced child sex abuse and those who had not, and by elevated TABS scores for counselors who had a higher caseload of trauma survivors than those who had fewer trauma survivors on their caseloads. The reliability of the measure in this study was good (α= .92).

Secondary Traumatic Stress. The Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004) is a measure of secondary traumatic stress symptomatology in individuals who have been impacted by their work with traumatized clients. The STSS consists of 17 items on a five-point Likert scale ranging from 1 (*never*) to 5 (*very often*). It is comprised of three subscales including the Intrusion, Avoidance, and Arousal subscales. Confirmatory factor analyses supported this three-factor model (i.e., intrusion, avoidance, and arousal; Bride et. al, 2004). A sample question from the Intrusion subscale is "It seemed as if I was reliving the trauma(s) experienced by my client(s)." A sample question from the Avoidance subscale is, "I avoided people, places, or things that reminded me of my work with clients." A sample question from the Arousal subscale is, "My heart started pounding when I thought of my work with clients." The STSS has good overall internal consistency reliability (alpha=.93). The alpha levels for the subscales were as follows: Intrusion (alpha=.93), Avoidance (alpha=.87), and Arousal (alpha=.83). There is a high rate of comorbidity among traumatic stress, depression, and anxiety (Bride et al., 2004); STSS scores correlated with social workers' ratings of the severity of depression and anxiety symptoms experienced in the past week, the extent to which their clients were traumatized, and the frequency with which their work related to traumatic stress (supporting convergent validity) (Bride et al., 2004). The reliability of the measure in this study was good (α= .92).

Burnout. The Maslach Burnout Inventory (MBI; Maslach & Jackson, 1996) is a self-report measure of burnout. The MBI consists of 22-items on a 7-point Likert scale ranging from 0 (*never*) to 6 (*every day*). The MBI has adequate test-retest reliability (r = .54-.82) and internal consistency reliability (r = .71-.90; Fitzpatrick & Wright, 2005). With regard to validity, factor analyses confirm three factors (i.e., emotional exhaustion, depersonalization,

and personal accomplishment). These three factors were not correlated with job satisfaction, social desirability, depression, and occupational stress, providing credible evidence for discriminant validity. The reliability of the measure in this study was good (α= .89).

Personal Trauma History. The Life Events Checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004) is a self-report measure of personal trauma history. It has 17 items on a four-point Likert scale ranging from 1 (*not sure*) to 4 (*happened to me*). The LEC has good test-retest reliability (r = .82, mean kappa = .61). Convergent validity with the Traumatic Life Events Questionnaire (TLEQ) was adequate (.55; Gray et al., 2004). The LEC and TLEQ are similarly correlated with the PTSD Checklist symptom severity (r = .34 – .48). The reliability of the measure in this study was adequate (α=.67).

Social Support. The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) measures perceived social support from three sources: family, friends, and significant others. It consists of 12 items for which the test taker can respond on a seven-point Likert scale ranging from 1(*very strongly disagree*) to 7 (*very strongly agree*). The MSPPS has high internal consistency for the overall measure (alpha= .91) and for the three subscales (alpha=.90, .91, and .95). This measure has demonstrated good convergent validity with the Social Support Behaviors scale (Kazarian & McCabe, 1991). The MSPSS also demonstrates high construct validity as evidenced by its negative relationship with anxiety and depressive symptoms (Zimet et al., 1988). The reliability of the measure in this study was good (α= .93).

Intent to Stay Employed. The Intent to Remain Employed – Child Welfare (IRE-CW; Ellett, 2000) scale was developed to assess child welfare workers' intentions to remain employed in child welfare jobs. It consists of nine items for which test takers respond to items on a four-

point Likert scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Confirmatory factor analyses support a one factor model (intention to remain employed in child welfare) (Ellett, 2000). The IRE-CW has good internal consistency (alpha = .86). The reliability of the measure in this study was good (α= .87).

Demographic Questionnaire. In addition to the above measures, the participants completed a short demographic questionnaire that was developed by the principal investigators (see Appendix B). In the demographic questionnaire, information on the following variables were collected: gender, age, ethnicity, current relationships status, parental status, current position at DHS, education level, duration of employment at DHS, number of families on caseload, county worked in, number of hours worked per week, and number of hours of formal trainings received that were directly related to trauma issues. Child welfare workers were also asked questions regarding their level of satisfaction and the number of hours of supervision received per week as well as their satisfaction with colleague support. Last, child welfare workers were asked to fill out two ordinal scales in which they ranked (a) what aspects of their job caused them the greatest amount of stress and (b) if court involvement caused the greatest amount of stress, which aspect of this was most stressful.

Results

Data Analysis

Preliminary analyses were performed on the TABS, STSS, MBI, IRE-CW, and questions assessing level of perceived social support from supervisors to ensure that there were no violations of the assumptions of normality, linearity, and homoscedasticity of residuals for continuous variables. All assumptions were met and no potential problems were revealed as a result of these preliminary analyses. Kendall's tau_b correlations, nonparametric measures of correlations were used to investigate the MSPSS and perceived level of social support from colleagues because of the extreme skewness and nonnormality of these variables. Kendall's tau_b correlations are recommended in extreme cases such as this and do not require specific data cleaning procedures (Howell, 2007). Several variables had cases with missing data; these cases were deleted for analyses of those variables.

Descriptive Statistics

Descriptive statistics for VT, STS, and burnout are reported in Table 1. The mean TABS score for the entire sample was 174.42 (*SD*=34.50), indicating an average level of VT in child welfare workers. On the STSS, child welfare workers scored an average of 45.80 (*SD*=12.25), in the severe range, indicating that this sample experiences very high levels of STS. On the MBI, child welfare workers reported high levels of emotional exhaustion, moderate levels of depersonalization, and high levels of personal accomplishment.

Table 1

Means, Standard Deviations, Range, and Categorization of Measures of Vicarious Traumatization, Secondary Traumatic Stress, and Burnout

Measures	Mean	SD	Range	Categorization
TABS (N= 125)				
Total	174.42	34.50	99-257	Average
Safety-Self	24.28	6.70	14-45	Average
Safety-Other	14.78	4.23	8-23	Average
Trust-Self	14.99	4.25	8-28	Average
Trust-Other	18.03	5.21	8-34	Low Average
Esteem-Self	14.88	4.43	9-29	Average
Esteem-Other	17.10	4.37	9-30	Average
Intimacy-Self	16.50	3.97	8-29	Average
Intimacy-Other	16.57	5.74	9-38	Average
Control-Self	21.79	5.50	11-37	Average
Control-Other	15.43	4.22	7-32	Average
STSS (N= 127)				
Total	48.50	12.25	18-84	Severe
Intrusion	13.57	4.17	6-25	Severe
Avoidance	18.26	5.31	7-34	Moderate
Arousal	13.97	3.75	5-25	Moderate
MBI (N=122)				
Total	53.24	18.52	10-95	--
EE	28.94	11.17	4-51	High
De	11.23	6.37	0-30	Moderate
PA*	12.95	6.06	0-30	High

Note: TABS is Trauma and Attachment Belief Scale. STSS is Secondary Traumatic Stress Scale. MBI is Maslach Burnout Inventory. EE is the Emotional Exhaustion subscale. De is the Depersonalization subscale. PA is the Personal Accomplishment subscale.
*Scored in opposite direction from EE or DP.

In regards to perceived social support of friends, family, and significant others, child welfare workers reported an average score of 67.65 (*SD*=12.27). The majority of participants (59.1%) reported that they did not have a regularly scheduled supervision whereas only 32.3% reported that they did have a regularly scheduled supervision. In regards to the number of hours of supervision received per week, 58 participants reported they received less than 1 hour of supervision per week (45.7%), 33 received 1 hour of supervision per week (26%), 18 received 2 hours of supervision per week (14.2%), 11 received 3 hours of supervision per week (8.7%), and five received over 5 or more hours of supervision per week (3.9%). Descriptive statistics for the availability of supervision, satisfaction with the amount of supervision received, and satisfaction with level of support from supervisors and colleagues is presented in Table 2.

Table 2

Frequencies of Availability of Supervision, Satisfaction with Amount of Supervision, and Satisfaction with Support from Supervisors and Colleagues

Variable					
	Never	Rarely	Sometimes	Frequently	Always
Availability of Supervisor	3 (2.4%)	20 (15.7%)	40 (31.5%)	44 (34.6%)	19 (15%)
	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
Amount of Supervision	9 (7.1%)	35 (27.6%)	28 (22.0%)	38 (29.9%)	16 (12.6%)
Level of Support from Supervisor	7 (5.5%)	16 (12.6%)	24 (18.9%)	51 (40.2%)	29 (22.8%)
Level of Support from Colleagues	2 (1.6%)	8 (6.3%)	22 (17.3%)	57 (44.9%)	38 (29.9%)

Of the total sample, 96% reported that they experienced at least one traumatic event. Because of the elevated rate of traumatic events, the number of traumatic events that child welfare workers experienced was used in this study. Child welfare workers reported that they experienced an average of 5.84 (SD=2.89) traumatic events during their lifetime.

Hypothesis 1

The first hypothesis was that child welfare workers who reported lower levels of perceived social support from friends, family, significant others, supervisors, and colleagues would report higher levels of VT, STS, and burnout than child welfare workers who reported higher levels of perceived social support. Using Kendall tau_b correlations, perceived level of social support from friends, family, and significant others (as measured by the MSPSS) was significantly and negatively correlated with VT (τ=-.23, $p<.01$), STS (τ=-.18, $p<.01$), and burnout (τ=-14, $p<.05$), indicating that higher levels of social support are related to lower levels of VT, STS, and burnout.

Vicarious Traumatization

Child welfare workers' level of VT was measured using self-report responses of the TABS (Pearlman, 2003). Their reports of VT were negatively correlated with self-reported levels of perceived social support from friends, family, and significant others (see Table 3). Further examination of subscales revealed that social support of friends, family, and significant others was significantly and negatively correlated with numerous subscales of the TABS including the Safety-Self, Trust-Other, Intimacy-Other, Esteem-Self, Esteem-Other, Control-Self, and Control-Other subscales. The MSPSS-Friends subscale was also significantly correlated with numerous subscales of the TABS.

Table 3

Correlations between Perceived Social Support of Friends, Family, and Significant Others and Vicarious Traumatization

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. TABS-Total	--	.56**	.39**	.47**	.59**	.50**	.60**	.58**	.54**	.63**	.51**	-.18**	-.15*	-.19**	-.16*
2. Safety-Self		--	.36**	.38**	.30**	.36**	.28**	.37**	.31**	.37**	.35**	-.10	-.19**	-.07	-.08
3. Safety-Other			--	.21**	.23**	.23**	.23**	.20**	.20**	.29**	.24**	-.08	-.14*	-.07	-.05
4. Trust-Self				--	.30**	.32**	.27**	.39**	.26**	.33**	.25**	-.003	-.10	.02	.001
5. Trust-Other					--	.30**	.51**	.37**	.57**	.46**	.33**	-.30**	-.31**	-.30**	-.24**
6. Intimacy-Self						--	.30**	.38**	.36**	.36**	.25**	-.11	-.20**	-.07	-.06
7. Intimacy-Other							--	.46**	.41**	.48**	.39**	-.29**	-.31**	-.26**	-.17**
8. Esteem-Self								--	.38**	.49**	.33**	-.18**	-.26**	-.18**	-.10
9. Esteem-Other									--	.38**	.29**	-.24**	-.17**	-.24**	-.17**
10. Control-Self										--	.46**	-.17**	-.22**	-.16**	-.11
11. Control-Other											--	-.28**	-.33**	-.25**	-.20**
12. Social Support-Total												--	.62**	.79**	.73**
13. Social Support-Friends													--	.46**	.45**
14. Social Support-Family														--	.63**
15. Social Support-SO															--

Note: TABS is Trauma and Attachment Belief Scale. SO is significant other

*p<.05
**p<.01

To assess child welfare workers' perceived level of social support from supervisors, three questions on the demographic questionnaire were used. These included, "When you need supervision regarding work-related trauma issues, is it available to you?," "How satisfied are you with the amount of supervision you receive from your supervisor?," and "How satisfied are you with the level of support you receive from your supervisor?" These questions were combined to provide a more reliable measure of perceived social support from supervisors (alpha=.85). The relationship between perceived social support from supervisors and VT was analyzed using Pearson product-moment correlation coefficient. There was a small, negative, and significant correlation between level perceived level of social support from supervisors and VT ($r=-.22$, $p<.05$).

The relationship between perceived level of social support from colleagues and VT was also investigated using a Kendall's tau_b correlation. To assess perceived level of social support form colleagues, child welfare workers were asked, "How satisfied are you with the level of support you receive from your co-workers?" There was no significant relationship between perceived levels of social support from colleagues and VT ($\tau = -.16$).

Secondary Traumatic Stress

Child welfare workers' level of STS was measured using the STSS (Bride et al., 2004). Kendall's tau_b correlational analyses revealed that perceived level of social support from friends, family, and significant others was significantly and negatively correlated with avoidance and arousal subscales but not the intrusion subscale of the STSS (see Table 4). Social support from friends was significantly correlated with the avoidance subscale of the STSS. Social support from family and significant others was significantly correlated with the avoidance and arousal subscales of the STSS (see Table 4).

Table 4

Correlations between Perceived Social Support of Friends, Family, and Significant Others and Secondary Traumatic Stress

Variable	1	2	3	4	5	6	7	8
1. STS-Total	--	.77**	.77**	.80**	-.18**	-.15*	-.19**	-.16*
2. STS-Intrusion		--	.54**	.65**	-.10	-.11	-.11	-.12
3. STS-Avoidance			--	.63**	-.21**	-.18**	-.28**	-.18**
4. STS-Arousal				--	-.17**	-.13	-.19**	-.15**
5. Social Support-Total					--	.62**	.79**	.73**
6. Social Support-Friends						--	.46**	.45**
7. Social Support-Family							--	.63**
8. Social Support-SO								--

Note: STS is secondary traumatic stress. SO is significant other

*p<.05

**p<.01

In assessing whether a relationship existed between perceived level of social support from supervisors and STS, a Pearson product-moment correlation coefficient was conducted. It was found that perceived level of social support from supervisors was negatively and significantly correlated with STS ($r=-.23$, $p<.05$). In looking at post-hoc correlations, it was found that perceived level of social support from supervisors was significantly correlated with the Avoidance subscale ($r=-.26$, $p<.01$) and the Arousal subscale of the STSS ($r=-.20$, $p<.05$).

Last, the relationship between perceived social support from colleagues and STS was examined. No significant correlations were found ($\tau=-.10$)

Burnout

Using a Kendall's tau_b correlations, perceived level of social support from friends, family, and significant others was significantly and negatively correlated with the total score on the MBI (τ=-.14, p<.05; see Table 5). Further correlations were run to determine if significant relationships were evidenced between the subscales of social support and burnout. Significant results were found between perceived social support from family and the MBI Emotional Exhaustion (τ=-.16, p <.05) and Personal Accomplishment subscales (τ=-.15, p<.05). There was also a small but significant relationship between social support from friends and the MBI Emotional Exhaustion subscale (τ=-.15, p<.05).

Table 5

Correlations between Perceived Social Support of Friends, Family, and Significant Others and Burnout

Variable	1	2	3	4	5	6	7	8
1. BO-Total	--	.72**	.59**	.43**	-.14*	-.10	-.17**	-.10
2. BO- EE		--	.40**	.21**	-.16**	-.15*	-.16*	-.11
3. BO-De			--	.23**	-.04	-.03	-.09	-.02
4. BO-PA				--	-.11	-.06	-.15*	-.09
5. Social Support-Total					--	.62**	.79**	.73**
6. Social Support-Friends						--	.46**	.45**
7. Social Support-Family							--	.63**
8. Social Support-SO								--

Note: BO is burnout. EE is emotional exhaustion. De is depersonalization. PA is personal accomplishment. SO is significant other.

*p<.05

**p<.01

The relationship between perceived social support from supervisors and burnout was investigated using Pearson product-moment correlation coefficient. There was a small, negative correlation between the two variables (r=-.16, p<.05), with higher levels of perceived social support being associated with lower levels of burnout.

Perceived level of social support from colleagues was found to be significantly associated with burnout (τ =-.19, p<.01). Further post-hoc analyses revealed that perceived

level of social support from colleagues was only significantly correlated with the MBI-Emotional Exhaustion subscale (τ =-.23, p<.01).

Hypothesis 2

The second hypothesis predicted that child welfare workers who reported lower levels of perceived social support from friends, family, significant others, supervisors, and colleagues would report a decreased intention to remain employed compared to child welfare workers who reported higher levels of social support. A small, significant correlation was found between child welfare worker's level of perceived social support from supervisors and their intention to remain employed at their current job (r=-.15, p<.05; see Table 6). There was also a small, yet significant relationship between child welfare workers' level of perceived social support from colleagues and their intention to remained employed (τ=-.21, p<.01). No significant relationships were evidenced between child welfare workers' perceived level of social support from friends, family, and significant others and their intention to remain employed.

Table 6

Correlations between Perceived Social Support of Friends, Family, Significant Others, Supervisors, and Colleagues and Intent to Remain Employed

Variable	1	2	3	4	5	6	7
1. SS-Total	--	.62**	.79**	.73**	.11	.12	-.03
2. SS-Friends		--	.46**	.45**	.13	.17*	.05
3. SS-Family			--	.63**	.09	.09	-.07
4. SS-SO				--	.07	.07	-.001
5. SS-Supervisor					--	.23**	-.15*
6. SS-Colleagues						--	-.21**
7. ITRE							--

Note: SS is social support. SO is significant others. ITRE is intent to remain employed.

*p<.05

**p<.01

Hypothesis 3

Last, it was predicted that child welfare workers who reported higher levels of VT, STS, and burnout would report a higher number of previous traumatic events than child welfare workers who reported a smaller number of previous traumatic events. The relationship between VT and number of previous traumatic events (as measured by the LEC) was investigated using Pearson product-moment correlation coefficients (see Table 7). There was a small, positive correlation between the two variables ($r=.22$, $p<.05$), indicating that higher levels of VT are related to a higher number of previous traumatic events. Further post-hoc correlations revealed significant, positive correlations between the Intimacy-Self,

Control-Other, Safety-Self, Safety-Other, and Esteem-Self subscales and the number of previous traumatic events.

Table 7

Correlations between Vicarious Traumatization and Number of Previous Traumatic Events

Variables	Number of Previous Traumatic Events
TABS-Total	.22*
1. Safety-Self	.23**
2. Safety-Other	.22*
3. Trust-Self	.10
4. Trust-Other	.10
5. Intimacy-Self	.18*
6. Intimacy-Other	.14
7. Esteem-Self	.29**
8. Esteem-Other	.06
9. Control-Self	.07
10. Control-Other	.19*

Note: TABS is Trauma and Attachment Belief Scale.

*p<.05

**p<.01

Contrary to this hypothesis, no significant correlations were found between the number of previous traumatic events and STS or burnout. Post-hoc correlations were run to determine if significant relationships existed between the number of previous traumatic events and the subscales of STS and burnout. The Avoidance subscale (r=.26, p<.01) and the

Arousal subscale ($r=.18$, $p<.05$) were both significantly related to number of previous traumatic events experienced by child welfare workers. No significant results were found between number of previous traumatic events and subscales of burnout.

Discussion

The purpose of this study was to investigate how perceived level of social support from friends, family, significant others, supervisors, and colleagues and a personal history of traumatic events are related to levels of VT, STS, and burnout among child welfare workers. As a group, child welfare workers experienced high levels of VT, STS, and burnout. These results are similar to previous research in which mental health workers have reported high levels of VT, STS, and burnout (Brady et al, 1999; Bride, 2007; Chrestman, 1999; Johnson & Hunter, 1997). For example, child protective workers were found to have higher levels of distress than those in the general population (Cornille & Meyers, 1999). In addition, this study provides support that perceptions of social support and personal history of traumatic events are related to VT, STS, and burnout.

Hypothesis #1

It was predicted that perceived social support from friends, family, significant others, supervisors, and colleagues would be negatively correlated with VT, STS, and burnout. This hypothesis was partially supported for VT. A significant relationship was found between the level of perceived social support from friends, family, significant others, and supervisors with VT. Child welfare workers with low levels of social support are more likely to experience VT symptomatology than those with high levels of social support. These results are similar to previous research in which social support was negatively related to VT (Adams et al., 2001; Follette, 1994).

The highest correlations between VT and social support were among perceptions of trust and control and perceived support from others. Child welfare workers with low levels of social support reported difficulty trusting or relying on other people and were uncomfortable when not in charge of situations. It is possible that child welfare workers who endorsed low levels of perceived social support did not trust or rely on other people because they lacked a support system to which they could turn. This may be due to child welfare workers frequent exposure to clients who have done awful things to children, which may be associated with their difficulty trusting and relying on other people. Additionally, because child welfare workers endorsed experiencing a high number of previous traumatic events (m=5.84), it is possible that they had difficulty trusting other people prior to their current employment. For example, child welfare workers who experienced abuse or sexual assault in the past may have greater difficulty trusting other people due to this experience. However, child welfare workers with low levels of support reported that they could trust their own thoughts and judgments.

No significant relationship was found between perceived social support from colleagues and VT. One reason that a significant relationship may not have existed between child welfare workers' perceptions of social support from colleagues and VT is that only one question was used to assess perceptions social support from colleagues and this may not have been adequate to measure this variable. Another possible reason that significant results were not found is that there was not enough variability in reports of social support from colleagues to see significant differences between participants. Child welfare workers in this study were satisfied overall with support they received from colleagues. Of the child welfare workers, 74.8% indicated that they were satisfied or very satisfied with the level of support they were

receiving from their colleagues. It is also possible that participant satisfaction with support from colleagues was not associated with VT.

The hypothesis that lower levels of perceived social support from friends, family, significant others, supervisors, and colleagues would be negatively related levels of STS was partially supported. Specifically, there was a significant relationship between lower levels of perceived social support from friends, family, significant others, and supervisors and higher levels of STS. This suggests either that lack of social support may be a risk factor for the development of STS or that those who perceive a lack of social support have more STS symptomatology.

The strongest correlations between STS and social support were evidenced on the Avoidance subscale of the STSS. Child welfare workers with low levels of social support from friends, family, significant others, and supervisors were more likely to avoid their clients, have difficulty recalling information related to their work with clients, experience detachment from others, have a diminished interest or participation in activities, feel emotionally numb, and experience a sense of a foreshortened future (Bride, 2007). These results are similar to previous findings in which social support was negatively correlated with STS (Schauben & Frazier, 1995; Kassam-Adams, 1999). Mental health workers who use social support as a coping mechanism report fewer PTSD symptoms than those who did not use social support as a coping mechanism (Schauben & Frazier, 1995).

No relationship between perceived social support from colleagues and STS was evidenced. Again, this may be due to a lack of variability in reported social support from colleagues or due to the fact that a single question was used to assess child welfare workers' level of perceived social support from colleagues.

The hypothesis that low levels of perceived social support from friends, family, significant others, supervisors, and colleagues would be related to high levels of burnout was supported. Although this statistically significant relationship was weak, findings indicate that child welfare workers with lower levels of social support reported higher levels of burnout. Child welfare workers with lower level of perceived social support from friends, family, supervisors, and colleagues reported feeling overworked and worn out by their current job duties. Social support from significant others did not play a significant role in the development of emotional exhaustion. This may be due to child welfare workers not viewing an association between significant others and being overly extended and exhausted at work. Child welfare workers in this sample reported that they were satisfied with their relationships with significant others as evidenced by scores on the MSPSS and 67 % indicated that they were married. These results are consistent with previous research in which researchers found that individuals with low levels of perceived social support reported high levels of burnout. (Capner & Caltabiano, 1993; Coster & Schwebel, 1997; Etzion, 1984, Kahill, 1988; Koeske, Kirk, & Koeske, 1993; Koeske & Koeske, 1989; Leiter, 1988; Ross, Altmaier, & Russell, 1989; Savicki & Cooley, 1987).

Hypothesis #2

The second hypothesis was that child welfare workers who reported lower levels of perceived social support from friends, family, significant others, supervisors, and colleagues would report a decreased intention to remain at their jobs than workers who reported higher levels of social support. This hypothesis was partially supported. Lower levels of perceived social support from supervisors and work colleagues were related to higher intentions among child welfare workers to leave their jobs. These results are similar to the findings found by

Ellet and Millar (2004) in which child welfare workers who reported higher levels of perceived social support were more likely to remain employed at their current job.

Contrary to predictions, there was no significant relationship between level of perceived social support from friends, family, and significant others and intention to leave their jobs. Work-related factors (i.e., perceived social support from supervisors and colleagues) were related to seeking other employment whereas personal relationships were not related to the desire to leave or remain at one's current job. These findings may be important for agencies to be cognizant of because strong social support at work is related to increased job retention. Therefore, it is important that agencies provide stronger social support within the work environment to retain employees.

Hypothesis #3

The third hypothesis was that child welfare workers who reported higher levels of VT, STS, and burnout would report a higher number of previous traumatic events than child welfare workers who reported a lower number of previous traumatic events. This hypothesis was partially supported. A higher number of previous traumatic events were only associated with higher levels of VT, but not STS or burnout. These results suggest that child welfare workers with histories of a high number of traumatic events experience the following: heightened concern about the general security of the world as well as their own safety and that of others, avoidance of personal conversations or experiences that invite emotional closeness, disruptions in their sense of self-worth, a need to control actions, feelings, and behaviors, and discomfort when they are not in charge of situations (Pearlman, 2003). These symptoms may greatly interfere with a child welfare worker's ability to work effectively with clients. Furthermore, the symptoms may interfere with child welfare workers' personal lives.

These results are consistent with other research findings in which mental health workers with a personal history of traumatic events are more likely to be vicariously traumatized than those without a history of traumatic events (Pearlman & Mac Ian, 1995). Additionally, in this sample, 96% of child welfare workers reported that they experienced a traumatic event. Due to the high number of child welfare workers experiencing a traumatic event, it is likely that many of the workers are experiencing distressing symptoms related to VT. It is also possible that experiencing VT is associated with personal memories of previous traumatic events.

Although no significant relationships existed between number of traumatic events and STS overall, significant correlations were found between the Avoidance and Arousal subscales of the STSS and number of previous traumatic events. Child welfare workers who reported a higher number of traumatic events were more likely to avoid their clients, have difficulty recalling information related to their work with clients, experience detachment from others, have a diminished interest or participation in activities, feel emotionally numb, and experience a sense of a foreshortened future. Further, they were more likely to experience physiological symptoms such as sleeping difficulties, irritability, concentration problems, hypervigilence, and an exaggerated startle response. STSS symptoms may significantly interfere in child welfare workers' professional and personal lives (Figley, 1995a). Because STS symptoms parallel PTSD symptoms, it is possible that child welfare workers' history of traumatic events, in conjunction with being exposed to their clients' traumatic experiences on a daily basis is causing elevated levels of emotional disruption (i.e., STS).

Contrary to hypotheses, no significant relationships were evidenced between number of previous traumatic events and dimensions of burnout among child welfare workers. This is

consistent with previous research in which mental health workers' own history of traumatic events was not associated with high levels of burnout (Follette, Polusny, & Milbeck, 1994; Stevens & Higgins, 2002). It is possible that exposure to traumatic events may have unique effects that are distinct from those of burnout (McCann & Pearlman, 1990).

Limitations and Directions for Future Research

Study design. As with any research, certain limitations are inherent in the study and must be noted. These issues include method of recruitment of participants, design of the study, lack of variability and validity within specific measures, and lack of agreement on construct definitions.

The sample consisted of a self-selected group of child welfare workers within two suburban counties in the state of Oregon. Therefore, results need to be interpreted with caution and may not generalize to other populations. Specifically, the participants of this study included primarily white females. It would be important to obtain a more heterogeneous group in the future, including a larger number of male and ethnically diverse child welfare workers. This would improve the generalizabiltity of results.

In this study, a cross-sectional design was used, and therefore cause cannot be inferred. Participants in this study were chosen based on a convenience sample and child welfare workers volunteered to participate in this study. In future research on VT, STS, and burnout in child welfare workers, longitudinal studies should be used to assess the progression and relationship of these factors with perceived level of social support from friends, family, significant others, supervisors, and colleagues and a personal history of traumatic events. Understanding the process of how some child welfare workers develop VT,

STS and burnout and others do not appear to experience distress would be essential in order to provide treatment to distressed case workers.

Many child welfare workers chose not to participate in this study. Some reasons that child welfare workers indicated that they did not want to participate in this study included that they were feeling overwhelmed and were too busy at work or were out of the office for work-related reasons. One female participant reported that she did not want to participate because the questionnaires would bring up too many of her concerns about the difficulties of her work. The participants who chose not to partake in this study may have provided valuable and insightful information to this study. Future research should address functioning of child welfare workers who report concerns about being overwhelmed or are overly busy at work to better understand barriers to research participation among this group. Many questions could be asked, such as a) are the surveys applicable to you?, b) are you too busy?, c) do you think that filling out questionnaires will be detrimental to your career?, and d) do you worry that the questionnaires will bring up past issues? Gathering this information may help researchers better understand VT, STS, and burnout among a broad array of child welfare workers.

Another limitation of this study is that there was a lack of variability in measures of perceived social support from friends, family, significant others, supervisors, and colleagues. Overall, the participants reported high levels of perceived social support. In the future, it would be beneficial to obtain a more heterogeneous sample that has greater variability in participants' reported level of perceived social support.

An additional drawback of this study was the lack of validated measures of perceived social support from supervisors and colleagues and intent to remain employed. The researchers in this study asked child welfare workers to answer three questions in the

demographic questionnaire about their level of support from supervisors and one question about their level of support from colleagues. The Intent to Remain-Employed Scale was obtained from an unpublished dissertation (Ellet, 2000). Therefore, the validity of these measures is in question and these results must be interpreted with caution. In future research, it would be an important to use well-validated and well-researched measures to assess child welfare workers level of perceived social support from supervisors and colleagues and their intentions to remain employed in their current position.

A qualitative approach may also be helpful in assessing which types of social support are most important to one's well-being. It would also be important to understand how supervisors respond to their employees evidencing symptoms of VT, STS, or burnout. Researchers could monitor how supervisors conduct individual and group supervision. This would help determine if these variables play a role in the development of VT, STS, and burnout.

Because of the high frequency of traumatic events reported by child welfare workers, it may be important to focus on this construct. It might be helpful to assess what specific types of traumatic events and to what extent child welfare workers have experienced traumatic events more carefully. It may be beneficial to use more comprehensive measures of histories of traumatic events. For example, the Traumatic Life Events Questionnaire (TLEQ) is one thorough assessment of history of traumatic events (Kubany, 2000). On the other hand, some researchers recommend that because VT is based on the constructivist perspective, defining a traumatic event requires the participant rather than the researcher to determine or define what is considered a traumatic event (Pearlman & Mac Ian, 1995). In other words subjective questions about perceptions of traumatic events may be used to determine if

events are traumatic. More research is needed to determine the most appropriate method to measuring histories of traumatic events.

Finally, it is important to note that the definitions of VT, STS, and burnout are inconsistent in the literature. Development of clear operational definitions of constructs including VT, STS, and burnout, which could be used by all researchers would be beneficial. Because the constructs of VT, STS, and burnout are complex, future researchers should continue to develop and validate measures to assess variables that may contribute or mitigate the effects of VT, STS, and burnout. The construct of a personal history of traumatic events may also need further clarification because researchers use various methods to assess personal history of traumatic events.

Other variables of interest. It would also be important to identify other variables that may be associated with the development of VT, STS, and burnout, including personal factors such as chronic stressors, spirituality, use of therapy, ethnicity, and age (Brady et al., 1997; Pearlman & Saakvitne, 1995; Trippany, Kress, & Wilcoxon, 2004). Researching specific organizational and workplace factors is also essential. Examples of workplace and organizational factors that may be associated with VT, STS and burnout include income, work conditions, amount of vacation and personal days one gets off from work, number of families on caseload, and number of years of employment as a child welfare worker (Brady et al., 1997; Catherall, 1995; Chrestman, 1995, Cunningham, 1999; Kassam-Adams, 1995; Schauben & Frazier, 1995). Furthermore, assessing protective factors that may prevent or ameliorate VT, STS, and burnout should be identified. Assessing these variables may further clarify what contributes to the development and maintenance of VT, STS, and burnout.

As mentioned previously, child welfare workers as a group reported high levels of perceived social support. Furthermore, the majority of child welfare workers reported that they are married (67.7%). It would be beneficial for future researchers to explore the association between marital satisfaction and VT, STS, and burnout.

Clinical Implications

It is important to note that 96% of this sample reported that they experienced a traumatic event. There was also an association between the number of traumatic events and the levels of VT reported by child welfare workers. This has important clinical implications in child welfare workers because they are working with maltreated children on a daily basis. It may be useful to determine if their work is causing higher levels of VT or if other variables (e.g., personal history of traumatic events) are also contributing to high levels of VT, STS, and burnout. This would allow researchers to develop new methods to prevent or ameliorate levels of VT, STS, and burnout.

It would be important to develop useful interventions to prevent or ameliorate VT, STS, and burnout among child welfare workers, especially considering the high number of previous traumatic events that were reported by participants in the current study. For example, organizations could increase the availability of supervision, implement peer supervision and consultation groups, and conduct training seminars on trauma for child welfare workers (Catherall, 1995; Trippany et al., 2004). These resources would provide child welfare workers with professional support, in which they could process the horrific stories and graphic imagery that are an inevitable part of their work (Pearlman & Mac Ian, 1995).

Summary

In conclusion, it was found that low levels of perceived social support were related to higher levels of VT, STS, and burnout. It was also found that lower levels of perceived social support of supervisors and colleagues were associated with a decreased intention to remain employed at the agency. Last, a higher number of previous traumatic events were associated with higher levels of VT and STS, but not burnout. These results highlight the need to acknowledge, address, and prevent VT, STS, and burnout in those who work with clients with experiences of traumatic events. Organizational changes that address these potential outcomes can help alleviate negative consequences of working with traumatized clients, help ensure quality services for the clients being treated, and increase job retention among child welfare workers. Identifying and ameliorating VT, STS, and burnout in child welfare workers is imperative because of the difficult, yet necessary work they conduct with maltreated children.

References

Adams, K. B., Matto, H. C., & Harrington, D. (2001). The traumatic stress institute belief scale as a measure of vicarious trauma in a national sample of clinical social workers. *Families in Society, 82* (4), 363-371.

Aidman, E. V., & Garro, A. (2005). Review of Traumatic and Attachment Belief Scale. *The sixteenth mental measurements yearbook.* Retrieved on November 15th, 2006, from http://gateway.ut.ovid.com.proxy.lib.pacificu.edu:2048/gw1/ovidweb.cgi.

American Psychiatric Association (2000). *Diagnostic and statistic manual of mental disorders* (Text revision). Washington, DC: Author.

Anderson, D. G. (2000). Coping strategies and burnout among veteran child protection workers. *Child Abuse and Neglect, 24* (6), 839-848.

Arvay, M. J., & Uhlemann, M. R. (1997). Counselor stress in the field of traumatology: A preliminary study. *Canadian Journal of Counseling, 30,* 193-210.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18*, 71-86.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Human Services, 84* (4), 463-470.

Benatar, M. (2003). A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *Journal of Trauma and Dissociation, 1* (3), 9-28.

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention, 6* (1), 1-9.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30* (4), 386-393.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice, 14* (1), 27-35.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work, 75* (10), 81-101.

Capner, M. & Caltabiano, M. L. (1993). Factors affecting the progression towards burnout: A comparison of professional and volunteer cousellors. *Psychological Reports, 73,* 555-561.

Catherill, D. R. (1999). Coping with secondary traumatic stress: The importance of the therapist's professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators,* (pp. 3-28). Lutherville, MD: Sidran Press.

Cerney, M. S. (1995). Treating the "heroic treaters." In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized,* (pp. 131-145). New York: Brunner/Mazel.

Chrestman, K. R. (1999). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators,* (pp. 3-28). Lutherville, MD: Sidran Press.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers- a literature review. *Journal of Psychiatric and Mental Health Nursing, 10,* 417-424.

Cornille, T. A., & Meyers, T. W. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology, 5* (1). Retrieved June 27, 2006, from http://www.fsu.edu/~trauma/art2v5i1.htm.

Coster, J. S., & Schwebel, M. (1997). Well-functioning on professional psychologists. *Professional Psychology: Research and Practice, 28* (1), 5-13.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48* (4), 451-459.

Dalton, L. (2001). Secondary traumatic stress and Texas social workers. Unpublished doctoral dissertation. Univeristy of Texas, Arlington.

Dane, B. (2000). Child welfare workers: An innovative approach for interacting with secondary trauma. *Journal of Social Work Education, 36* (1), 27-38.

Davis-Sacks, M. L., Jayaratne, S., & Chess, W. A. (1985). A comparison of the effects of social support on the incidence of burnout. *Social Work,* 240-244.

Ellet, A. J. S. (2000). Human caring, self-efficacy beliefs, and professional organizational culture correlates of employee retention in child welfare (Doctoral dissertation, University of Missouri, 2000). *Dissertation Abstracts International Section A: Humanities and Social Sciences, 61* (8-A), pp. 3350.

Ellett, A. J., & Millar, K. I. (2004). Professional organizational culture and retention in child welfare: Implications for continuing education for supervision and professional development. *The International Journal of Continuing Social Work Education, 7* (3), 30-38.

Epstein, S. (1991). The self-concept, the traumatic neurosis, and the structure of personality. In R. Hogan (Ed.), *Perspective in Personality* (Vol. 3A, pp. 63-98). London: Jessica Kingsley.

Eriksson, C., VandeKemp, H., Gorsuch, R., Hoke, S., & Foy, D. (2001). Trauma exposure and PTSD symptoms in international relief and developmental personnel. *Journal of Traumatic Stress, 13,* 205-211.

Etzion, D. (1984). Moderating effect of social support on the stress-burnout relationship. *Journal of Applied Psychology, 69,* 615-622.

Figley, C. R. (1995a). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.

Figley, C. R. (1995b). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary Traumatic Stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-28). Lutherville, MD: Sidran Press.

Figley, C. R. (1995c). Systematic traumatization: Secondary traumatic stress disorder in family therapists. In R. H. Mikesell, D. Lusterman, & S. H. McDaniel (Eds). *Integrating Family Therapy: Handbook of Family and Systems Theory* (pp. 571-581). Washington DC: American Psychological Association.

Fitzpatrick, R. & Wright, C. R. (2005). Review of Maslach Burnout Inventory. *The sixteenth mental measurements yearbook.* Retrieved on November 15th, 2006, from http://gateway.ut.ovid.com.proxy.lib.pacificu.edu:2048/gw1/ovidweb.cgi.

Flannery, R. B. (1990). Social support and psychological trauma: A methodological review. *Journal of Traumatic Stress, 3* (4), 593-611.

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms and impact of providing services to child sexual abuse survivors, *Professional Psychology: Research and Practice, 25* (3), 275-282.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30,* 159-165.

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment, 11* (4), 330-341.

Howell, D. C. (2007). *Statistical Methods for Psychology* (6th Ed.) Belmont, CA: Thomson Wadsworth.

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15* (4), 393-412.

Jayaratne, S., Chress, W. A., & Kunkel, D. A. (1986). Burnout: Its impact on child welfare workers and their spouses. *Social Work,* 53-58.

Johnson, C. N. & Hunter, M. (1997). Vicarious traumatization in counselors working in the New South Wales sexual assault service: An exploratory study. *Work & Stress, 11* (4), 319-328).

Kahill, S. (1988a). Relationship of burnout among professional psychologists to professional expectations and social support. *Psychological Reports, 59,* 1043-1051.

Kahill, S. (1988b). Symptoms of professional burnout: A review of the empirical evidence. *Canadian Psychology, 29* (3), 284-297.

Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary Traumatic Stress: Self-care issues for clinicians, researchers, and educators* (pp. 37-48). Lutherville, MD: Sidran Press.

Kazarian, S. S., & McCabe, S. B. (1991). Dimensions of social support in the MSPSS: Factorial structure reliability, and theoretical implications. *Journal of Community Psychology, 19,* 150-160.

Koeske, G. F., Kirk, S. A., & Koeske, R. D. (1993). Coping with job stress: Which strategies work best? *Journal of Occupational and Organizational Psychology, 66,* 319-335.

Koeske, G. F., & Koeske, R. D. (1989). Work load and burnout: Can social support and perceived accomplishment help? *Social Work, 34,* 243-248.

Kubany, E. S., Haynes, S. N., Leisen, M. B., Owens, J. A., Kaplan, A. S., Watson, S. B., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment, 12,* 210-224.

Leiter, M. P. (1988). Burnout as a function of communication patterns: A study of a multidisciplinary mental health team. *Group and Organization Studies, 13* (1), 111-128.

Lerias, D., & Bryne, M. K. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health, 19,* 129-138.

Maslach, C. (1982). *Burnout: The cost of caring.* Englewood Cliffs, NJ: Prentice-Hall.

Maslach, C., & Jackson, S. E. (1984). Burnout in organizational settings. *Applied Social Psychology Annual, 5,* 133-153.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory manual.* Mountain View, CA: CPP Inc.

McCann, L. I., & Pearlman, L. A. (1992). Constructivist self-development theory: A theoretical framework for assessing and treating traumatized college students. *Journal of American College Health, 40,* 189-196.

McCann, L. I., & Pearlman, L. A. (1990a). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3* (1), 131-149.

McCann, L., & Pearlman, L. A. (1990b). Vicarious traumatization: Emotional costs of working with survivors. *Treating Abuse Today, 3* (5), 28-31.

McLean, S., Wade, T. D., & Encel, J. S. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout, and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy, 31,* 417-428.

Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social Service Review, 625-661.*

Motta, R., Suozzi, J., & Joseph, J. (1994). Assessment of secondary traumatisation with an emotional stroop task. *Perception and Motor Skills, 78,* 1275-1280.

Munroe, J., Shay, J., Fisher, L., Makary, C., Rapperport, K., & Zimering, R. (1995). Preventing compassion fatigue: A team treatment model. In C. Figley (Ed.), *Compassion Fatigue: Coping with secondary traumatic stress in those who treat the traumatized* (pp. 209-231). New York: Bruner/Mazel.

Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare, 132* (1), 3-26.

Nissley, J. A. (2005). Prospective and retrospective examinations of factors related to intention to leave and turnover among public child welfare workers. (Doctoral dissertation, University of Southern California, 2005). *Dissertation Abstracts International Section A: Humanities and Social Sciences, 65*(9-A), pp. 3572.

Nissley, J. A., Mor Barak, M. E., & Levin, A. (2005). Stress, social support, and workers' intentions to leave their jobs in public child welfare. *Administration in Social Work, 29* (1), 79-100.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32* (2), 341-347.

Oliveri, M. K., & Waterman, J. (1993). Impact on therapists. In J. Waterman, R. J. Kelly, M. K. Oliveri, & J. McCord (Eds.), *Behind the playground walls: Sexual abuse in preschools* (pp. 190-202).

Ozer, E. J., Best, S. R., Lipsey, T. L., Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129* (1), 52-73.

Parry, J. K. (1989). Mutual support groups: Do they relieve stress? *The Jewish Social Work Forum, 25,* 43-49.

Pearlman, L. A. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators,* (pp. 3-28). Lutherville, MD: Sidran Press.

Pearlman, L. A. (2003). *Trauma and Attachment Belief scale manual*. Los Angeles: Western Psychological Services.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists, *Professional Psychology – Research and Practice*, *26* (6), 558-565.

Pearlman, L. A., & Saakvitne, K.W. (1995b). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Pearlman, L. A., & Saakvitne, K. W. (1995a). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-177). New York: Brunner/Mazer.

Piaget, Jean (1950). *The Psychology of Intelligence*. New York: Routledge.

Resick, P. A., & Schnicke, M. K. (1996). *Cognitive Processing therapy for rape victims: A treatment manual.* Newbury Park, CA: SAGE Publications.

Rosenbloom, D., Pratt, A., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. Stamm (Ed.), *Secondary Traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 65-79). Lutherville, MD: Sidran.

Ross, R., Altmaier, E., & Russell, D. (1989). Job stress, social support, and burnout among counseling center staff. *Journal of Counseling Psychology, 36,* 464-470.

Rycraft, J. R. (1994). The party isn't over: The agency role in the retention of public child welfare caseworkers. *Social Work, 39* (1), 75-80.

Salston, M. D., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16* (2), 167-174.

Savicki, V. & Cooley, E. (1987). The relationship of work environment and client contact to burnout in mental health professionals. *Journal of Counseling and Development, 65,* 259-262.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19,* 49-64.

Sexton, L. (1999). Vicarious traumatisation of counselors and effects on their workplaces. *British Journal of Guidance and Counseling, 27* (3), 393-403.

Smith, B. D. (2005). Job retention in child welfare: Effects of perceived organizational support, supervisor support, and intrinsic job value. *Children and Youth Services Review, 27,* 153-169.

Sommers, C. (2003). Vicarious traumatization and the role of supervision: An exploration of sexual violence counselors' stories. *North Central Association for Counselor Education and Supervision Spring 2003 Newsletter.* Retrieved January 28, 2007 from http://www.siu.edu/~epse1/cox/naces/webnewsletterspring03.htm.

Stamm, B. (Ed). (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville, MD: Sidran Press.

Stevens, M., & Higgins, D. J. (2002). The influence of risk and protective factors on burnout experienced by those who work with maltreated children. *Child Abuse Review, 11,* 313-331.

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious traumatization: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82,* 31-37.

U.S. Department of Health and Human Services. (2006). *Child Maltreatment 2004*. Washington, DC: U.S. Government Printing Office. Retrieved January 12, 2007, from http://www.acf.hhs.gov/programs/cb/pubs/cm04/cm04.pdf.

Way, I., VanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19* (1), 49-71.

Weiss, D., Marmar, C., Metzler, T., & Ronfeldt, H. (1995). Predicting symptomatic distress in emergency personnel. *Journal of Consulting and Clinical psychology, 63,* 361-368.

Wilson, J., & Lindy, J. (1994). Empathic strain and countertransference. In J. P. Wilson & J. D. Lindy (Eds.), *Counter-transference in the treatment of PTSD* (pp. 5-30). New York: Guilford Publications.

Zimet, Dahlem, Zimet, & Farley (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52* (1), 30-41.

Appendix A

PACIFIC UNIVERSITY
INFORMED CONSENT TO ACT AS A RESEARCH PARTICIPANT

WORK-RELATED STRESS
AMONG CHILD WELFARE WORKERS

Investigator(s) Contact Information

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1. Introduction and Background Information

You are invited to be in a research study investigating the impact of working with traumatized clients on child welfare workers. You were invited to participate because you are a child welfare worker or supervisor in the State of Oregon. Please read this form carefully and ask any questions you may have before agreeing to be in this study.

This study is being conducted by Donna Fogg, Allison Osborn, Suzanne Sheppard, and Deborah Wise, Ph.D. The purpose of this study is to better understand how social support, self-efficacy, and optimism are associated with work-related stress.

2. Study Location and Dates

We anticipate the study will begin in January, 2007 and be completed by July, 2007. Questionnaires will be administered at the DHS offices in Washington County and Clackamas County.

3. Procedures

If you agree to be in this study, we will ask you to fill out nine brief paper and pencil questionnaires. The information obtained will be confidential. "Confidential" means that any information you provide in this study will not be shared with anyone other than the researchers named above, and your name will not be linked with any information you provide in this study. The questionnaires will be kept in a locked cabinet at Pacific University, and the signed informed consent forms will be kept separately in another locked cabinet at Pacific University. The amount of time it will likely take to complete questionnaires is between 15 and 30 minutes.

4. Participants and Exclusion

Only child welfare workers and supervisors in the State of Oregon will be included in the study. All participants must be currently employed by Oregon's Department of Human Services in the position of Social Service Assistant, Social Service Specialist I, Social Service Specialist II, or Child Welfare Supervisor. Participants who do not meet the above criteria will be excluded from the study. If participants think that the risks of completing the questionnaires outweigh the benefits, they are free to withdraw from the study at any time and to not return the questionnaires to the principal investigators. Should participants choose to withdraw from the study prior to completion, they will still be entered in the drawing for the gift cards.

5. Risks and Benefits

There are risks and benefits to participating in this research. Possible risks include: some participants may experience mild distress at answering questions regarding their current level of stress and anxiety, as well as their past, especially if their past involved traumatic experiences. However, the questionnaires are noninvasive and appear to pose no physical risks to participants. If participants do experience distress during or after completing the questionnaires, they will be referred to Pacific University Psychological Service Center for further assistance.

There are no direct benefits to participants for participating in this study. However, your participation may aid in our understanding of factors that are associated with work-related stress among caseworkers. This might help DHS in determining if employees are experiencing work-related stress and if these experiences are related to workers intending to leave their jobs.

6. Alternatives Advantageous to Participants

Not applicable

7. Participant Payment

All participants will be entered into a drawing to win one of two $50 gift cards at a local store. All participants will receive lunch or dinner while they complete the surveys.

8. Promise of Privacy

This study is confidential. Data that is collected will be kept in a password-protected computerized database. Any information you provide in this study will not be shared with anyone other than the researchers, and your name will not be linked with any information you provide in this study. The questionnaires will be kept in a locked cabinet at Pacific University, and the signed informed consent forms will be kept separately in another locked cabinet at Pacific University. If the results of this study presented or published, we will not include any information that would make it possible to identify you as an individual, and DHS will be identified as a child protective services agency in a Northwestern state.

9. Voluntary Nature of the Study

Your decision whether or not to participate will not affect your current or future relations with Pacific University or DHS. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. Should you choose to withdraw from the study prior to completion, you will still be entered in the drawing for the gift cards.

10. Compensation and Medical Care

During your participation in this project you are not a Pacific University clinic patient or client, nor will you receive psychotherapy services as a result of your participation in this study. If you are injured during your participation in this study and it is not the fault of Pacific University, the investigators, or any organization associated with the study, you should not expect to receive compensation or medical care from Pacific University, the investigators, or any organization associated with the study.

Your participation in this study is not a part of your job responsibilities. You will need to complete the questionnaires during non-work time (i.e., during lunch, breaks, before or after work hours). You will not be paid overtime for your participation in this study.

11. Contacts and Questions

The investigators will be happy to answer any questions you may have at any time during the course of the study. The investigators can be reached as follows: Donna Fogg (503-294-7401 x2047 or fogg4456@pacificu.edu), Allison Osborn (503-352-2462 or alieosborn@pacificu.edu), Suzanne Sheppard (503-352-2466 or mars5143@pacificu.edu), or

Deborah Wise, Ph.D. (503-352-2615 or dwise@pacificu.edu. If you are not satisfied with the answers you receive, please call Pacific University's Institutional Review Board, whose chairperson is Krista Brockwood, Ph.D., at (503) 352 –2616 to discuss your questions or concerns further. All concerns and questions will be kept in confidence.

12. Statement of Consent

I have read and understand the above. All my questions have been answered. I am either 18 years of age or over, or my parent / guardian has given consent for my participation. I have been given a copy of this form to keep for my records.

Participant's Signature Date

Participant contact information:

Street address: _____
_____
_____

Telephone: _____
Email: _____

This contact information is required in case any issues arise with the study and participants need to be notified and/or to provide participants with the results of the study if they wish. We will use this information to contact you if you are a winner in the gift card drawing.

Would you like to have a summary of the results after the study is completed? ___Yes
____No

Investigator's Signature_____

Appendix B

Demographic Questionnaire

Please answer the following questions to the best of your ability by checking off the response you feel best describes you.

1. What is your age (in years)? _____

2. What is your gender?

Male _____ Female _____

3. What is your ethnicity?

Caucasian___ African American___ Asian___ Native American___

Hispanic___ Other (please specify)_____

4. What is your current relationship status? (check all that apply)

Married/Partnered___ Single___ Divorced___ Widowed___ Separated___

Other (please specify)_____

5. Are you a parent? Yes___ No___ If you answered yes, how many children do you have under the age of 18?

0___ 1___ 2___ 3___ 4___ 5 or more___

6. What is your current position at DHS?

Supervisor ___ Social Service Specialist I___ Social Service Specialist II ___

Social Service Assistant___

7. What is the highest degree you have earned to date?

Less than High School Diploma/GED___ High School Diploma/GED___

Associate's Degree___ Bachelor's Degree (please specify)___

Post Graduate Degree (please specify)_____ Other (please specify)_____

8. Approximately how long have you worked at DHS? (Please list years and months, for example 5 years, 10 months) _____

9. How many families do you currently carry on your caseload?

0-5___ 6-10___ 11-15___ 16-20___ 21-25___ 26-30___ 31-35___

36-40___ Over 40___ N/A___

10. What county do you work in? Washington___ Clackamas___

11. On average, how many hours do you work per week?

Below 10___ 10-20___ 21-30___ 31-40___ Over 40___

12. Do you have a regularly scheduled time for supervision? Yes___ No___

13. Approximately how many hours of supervision do you receive per week?

Below 1___ 1___ 2___ 3___ 4___ 5___ Over 5___

14. When you need supervision regarding work-related trauma issues, is it available to you? (circle one)

Never Rarely Sometimes Frequently Always

15. How satisfied are you with the amount of supervision you receive?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied

16. How satisfied are you with the level of support you receive from your supervisor?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied

17. How satisfied are you with the level of support you receive from your co-workers?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied

18. How many hours of formal training (seminars, workshops, etc.) do you have with trauma- related issues at this agency?

0-5___ 6-10___ 11-15___ 16-20___ 21-25___ 26-30___ Over 30___

19. Would you like to receive additional formal training on trauma-related issues?

Yes___ No___

20. What aspects of your job cause you the greatest amount of stress? Please rank from 1 (greatest amount of stress) to 10 (least amount of stress)

Amount of work _____

Computer systems _____

Court work _____

Interactions with clients _____

Interactions with CRB/CASA programs _____

Interactions with community service providers _____

Obtaining resources for clients _____

Paper work _____

Complying with policy _____

Other (please specify) _____

21. If court work causes you a great amount of stress, which aspect of the work is most stressful? Please rank from 1 (greatest amount of stress) to 7 (least amount of stress)

Written court report___

Oral presentation of case to the court___

Working with attorneys___

Testifying___

Lack of legal representation___

Time spent at court house waiting for hearing to take place___

Other (please specify)_____

TRAUMA AND ATTACHMENT BELIEF SCALE

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please mark next to the number to each item which you feel most clearly matches your own beliefs about yourself and your world. Try to complete every item.

Thank you.

TABS ITEMS

1. I believe I am safe

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

2. You can't trust anyone

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

3. I don't feel like I deserve much

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

4. Even when I am with friends and family, I don't feel like I belong

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

5. I can't be myself around people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

6. I never think anyone is safe from danger

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

7. I can trust my own judgment

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

8. People are wonderful

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

	Strongly		Somewhat	Somewhat		Agree
9.	When my feelings are hurt, I can make myself feel better					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
10.	I am uncomfortable when someone else is the leader					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
11.	I feel like people are hurting me all the time					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
12.	If I need them, people will come through for me					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
13.	I have bad feelings about myself					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
14.	Some of my happiest times are with other people					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
15.	I feel like I can't control myself					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
16.	I could do serious damage to someone					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
17.	When I am alone, I don't feel safe					
	1	2	3	4	5	6
	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
18.	Most people ruin what they care about					
	1	2	3	4	5	6
	Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

19. I don't trust my instincts

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

20. I feel close to lots of people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

21. I feel good about myself most days

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

22. My friends don't listen to my opinion

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

23. I feel hollow inside when I am alone

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

24. I can't stop worrying about others' safety

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

25. I wish I didn't have feelings

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

26. Trusting people is not smart

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

27. I would never hurt myself

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

28. I often think the worst of others

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

29. I can control whether I harm others

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

30. I'm not worth much

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

31. I don't believe what people tell me

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

32. The world is a dangerous place

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

33. I am often in conflicts with other people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

34. I have a hard time making decisions

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

35. I feel cut off from people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

36. I feel jealous of people who are always in control

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

37. The important people in my life are in danger

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

38. I can keep myself safe

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

39. People are no good

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

40. I keep busy to avoid my feelings

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

41. People shouldn't trust their friends

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

42. I deserve to have good things happen to me

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

43. I worry about what other people will do to me.

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

44. I like people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

45. I must be in control of myself

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

46. I feel helpless around adults

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

47. Even if I think about hurting myself, I won't do it

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

48. I don't feel much love for anyone

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

49. I have good judgment

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

50. Strong people don't need to ask for help

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

51. I am a good person

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

52. People don't keep their promises

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

53. I hate to be alone

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

54. I feel threatened by others

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

55. When I am with people, I feel alone

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

56. I have problems with self-control

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

57. The world is full of people with mental problems

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

58. I can make good decisions

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

59. I often feel people are trying to control me

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

60. I am afraid of what I might do to myself

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

61. People who trust others are stupid

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

62. I am my own best friend

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

63. When people I love aren't with me, I believe they are in danger

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

64. Bad things happen to me because I am a bad person

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

65. I feel sage when I am alone

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

66. To feel okay, I need to be in charge

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

67. I often doubt myself

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

68. Most people are good at heart

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

69. I feel bad about myself when I need help

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

70. My friends are there when I need them

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

71. I believe that someone is going to hurt me.

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

72. I do things that put other people in danger

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

73. There is an evil force inside of me

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

74. No one really knows me

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

75. When I am alone, it's as if there's no one there, not even me

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

76. I don't respect the people I know best

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

77. I can usually figure out what's going on with other people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

78. I can't do good work unless I am the leader

1	2	3	4	5	6
Disagree	Disagree	Disagree	Agree	Agree	Strongly

Strongly		Somewhat	Somewhat		Agree

79. I can't relax

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

80. I have physically hurt people

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

81. I am afraid I will harm myself

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

82. I feel left out everywhere

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

83. If people really knew me, they wouldn't like me.

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

84. I look forward to time I spend alone.

1	2	3	4	5	6
Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree

Secondary Traumatic Stress Scale

The following is a list of statements by persons who have been impacted by their work with traumatized people. **Read each statement, then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.**

1.) I felt emotionally numb.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

2.) My heart started pounding when I thought about my work with clients.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

3.) It seemed as if I was reliving the trauma(s) experienced by my clients.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

4.) I had trouble sleeping.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

5.) I felt discouraged about the future.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

6.) Reminders of my work with clients upset me.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

7.) I had little interest in being around others.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

8.) I felt jumpy.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

9.) I was less active than usual.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

10.) I thought about my work with clients when I didn't intend to.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

11.) I had trouble concentrating.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

12.) I avoided people, places or things that reminded me of my work with clients.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

13.) I had disturbing dreams about my work with clients.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

14.) I wanted to avoid working with some clients.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

15.) I was easily annoyed.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

16.) I expected something bad to happen.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

17.) I noticed gaps in my memory about my work with clients.

Never	Rarely	Occasionally	Often	Very often
1	2	3	4	5

Life Events Checklist

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event, check one or more of the boxes to the right to indicate that (a) It *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (c) you're *not sure* if it applies to you, or (e) it *doesn't apply* to you.

Mark *only one* item for any single stressful event you have experienced. For events that might fit more than one item description, choose the one that fits best.

Be sure to consider your *entire life* (growing up, as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car or boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)	N/A				
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else		N/A	N/A		
17. Any other stressful event or experience					

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

1.) There is a special person around when I am in need

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

2.) There is a special person with whom I can share my joys and sorrows

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

3.) My family really tries to help me

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

4.) I get the emotional help and support I need from my family

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

5.) I have a special person who is a real source of comfort to me

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

6.) My friends really try to help me

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

7.) I can count on my friends when things go wrong

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

8.) I can talk about my problems with my family

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral Agree	Mildly Agree	Strongly Agree	Very Strongly
1	2	3	4	5	6	7

9.) I have friends with whom I can share my joys and sorrows

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral Agree	Mildly Agree	Strongly Agree	Very Strongly
1	2	3	4	5	6	7

10.) There is a special person in my life who cares about my feelings

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral Agree	Mildly Agree	Strongly Agree	Very Strongly
1	2	3	4	5	6	7

11.) My family is willing to help me make decisions

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral Agree	Mildly Agree	Strongly Agree	Very Strongly
1	2	3	4	5	6	7

12.) I can talk about my problems with my friends

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral Agree	Mildly Agree	Strongly Agree	Very Strongly
1	2	3	4	5	6	7

Intent to Remain Employed-Child Welfare

Directions: This section of the survey asks you to make a series of judgments about your personal attitudes and beliefs. The best answer is the one that most accurately reflects your personal views and opinions. Please respond to each statement using the scale provided below. Fill out each item that best corresponds to the strength of your disagreement or agreement.

1. I intend to remain in child welfare as my long-term professional career.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

2. I will remain in child welfare even though I might be offered a position outside of child welfare with a higher salary.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

3. I would leave child welfare work tomorrow if I was offered a job for the same salary but with less stress.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

4. The personal and professional benefits outweigh the difficulties and frustrations of working in child welfare.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

5. I am actively seeking other employment.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

6. I feel the personal and professional gratification of working in child welfare to be greater than those in other professions.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

7. I frequently think about quitting my job.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

8. I am committed to working in child welfare even though it can be quite stressful at times.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4

9. My intention to remain employed in child welfare is stronger than that of most of my colleagues.

Strongly Agree	Disagree	Agree	Strongly Agree
1	2	3	4